

Using Community Health Workers: Discipline and Hierarchy in Ethiopia's Women's Development Army*

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Abstract

In this article, we use semi-structured interviews and documents produced by Ethiopian government officials and international health donors to examine two key features of the nation's CHW program: (1) the process and criteria of selecting community health workers; and (2) policies, rhetoric, and experiences of payment and empowerment. We examine these from the varied perspectives of district health officials, Health Extension Workers, and leaders and members within Ethiopia's so-called Women's Development Army, whom we interviewed during 2012-2014. According to national policymakers and policy documents, the goals of the Women's Development Army are twofold: first, to reduce mortality and second, to produce "model" women, who discipline themselves and their neighbors to enact healthy behaviors. The Army is supposed to simultaneously "empower" these women to be more autonomous from husbands and more active in development-oriented work. Yet one of the key criteria sought by district-level health officials—willingness to "accept what we teach them and implement what we tell them"—highlights that Army leaders are to remain subordinate to government health officials. Many female members of the Women's Development Army expressed ambivalence about their selection, particularly as the position was unpaid. Some questioned why women were expected to volunteer when men had previously been paid to do similar work. These data emphasize the differences in goals, aims, and experiences among various actors involved in CHW programs, and the need for researchers to address whether or not respondents are comfortable to express perspectives that might question dominant goals and discourses.

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Introduction

At the same time that large-scale community health worker programs have important implications for population health, such programs also reflect important changes in sociality, ideology, models of citizenship, and political “participation”, particularly among women in various locales (Maes and Kalofonos 2013). Social scientists studying recent CHW programs, as well as public health professionals with long experience designing, managing, and implementing CHW programs, have both offered helpful understandings of community health workers, centering on the ways in which the work of CHWs may reflect true community “participation” in health versus simple implementation of top-down demands (Kalofonos 2014; Morgan 2001; Pérez and Martinez 2008; Sabo, et al. 2013). Anthropologist Alex Nading describes how community health workers in a suburb of Managua, Nicaragua, for instance, perform the role of extending “downward” the state’s bureaucratic desires to discipline and monitor the behaviors and beliefs of local people. At the same time, community health workers there are some of the only state actors who genuinely respect local people’s realities, knowledge, and desires, and who advocate “up” on their behalf, if in small ways, so that that they might not be treated as so unworthy, noncompliant, or otherwise excludable citizens (Nading 2013). In Khayelitsha, a township outside of Cape Town, South Africa, Swartz (2013) finds that older CHWs see younger CHWs as self-interested and privileged aspiring technicians focused on quantitative measures of productivity and population health. The older workers consider themselves as more caring and oriented towards social justice (Swartz 2013).

The roles and experiences of CHWs vary depending on historical and current political-economic contexts (Nichter 1999; Maes and Kalofonos 2013; Wayland and Crowder 2002;

Nading 2013; Swartz 2013). In the case of South Africa described by Swartz, animosities between older and younger CHWs can only be understood against the backdrop of apartheid and intense desires among black South Africans for both economic opportunities and social solidarity. In the case of Nicaragua described by Nading, the ways in which CHWs embody the role of broker between the state and citizens was shaped by the Nicaraguan Revolution and politics that unfolded after the election of Ortega in 2006. Yet across contexts, CHWs navigate a similar set of social and political dynamics centering on technocratic and disciplining commands from above and concerns with being seen as good citizens by the people who draw on their services (e.g., Kalofonos 2014).

In this paper we focus on policies and practices involved in the creation of a new nationwide CHW program, the all-female Health Development Army in Ethiopia. Like other low-income countries, Ethiopia has both a critical lack of health workers and high maternal and infant mortality. Ethiopia's leaders and international donors have attempted to fix both of these problems in part through a set of community health worker-focused investments and reform. In the past ten years, Ethiopia's central government/party has trained, deployed, and supervised thousands of salaried community health workers as part of its Health Extension Program. Health Extension Workers, as they are called, are all women of at least 18 years of age, have at least ten years of schooling, and come from the same rural areas that they serve (FMOH 2007). They are deployed to each of Ethiopia's ~15,000 *kebeles* (the lowest government administrative unit, roughly synonymous with village) to work out of rudimentary health posts. From their posts, they offer a long list of health "packages", including preventive, promotive, and curative primary health care. In return for their work, HEWs receive a monthly salary of about 100 USD (CNHDE 2011; FMOH 2007; FMOH 2011).

In 2011, the government announced it would establish what it calls a “Women’s Development Army”.¹ The Army would incorporate *all* of the adult women living in Ethiopia’s countryside. One woman out of every five households would become a Women’s Development Army leader, chosen for her status as a “model woman,” a distinction that hinges on having adopted a certain lifestyle deemed ‘healthy’ and ‘development-minded’ by leaders in Ethiopia’s central party/state. Army leaders (as “model women”) are to take much of the burden of outreach off the shoulders of HEWs, who previously were tasked with leading all women in their catchment area towards a ‘healthy’ lifestyle (CNHDE 2011; FMOH 2011; Teklehaimanot and Teklehaimanot 2013). These leaders thus are to operate as unpaid volunteers under the supervision of Health Extension Workers, carrying out a number of tasks, including helping during immunization campaigns, keeping track of pregnancies and illnesses, and relaying messages between households and HEWs. Ultimately, leaders are to lead other women around them toward a healthy lifestyle centering on dutifully maintaining household hygiene and seeking primary health care, including vaccinations, antenatal care and facility (i.e. health center) births in particular. The Women’s Development Army is explicitly based on a theory of behavior change through admiration and copying of these “model” women (Provost 2014). Recent qualitative work conducted in Amhara regional state by Banteyerga (2014) suggests that through the Women’s Development Army, Ethiopia’s government is further attempting to empower women to “take a lead in dealing with their health problems” and specifically to ask questions and even demand more accessible and higher quality primary health care services. Donors such as USAID and the Gates Foundation have generally repeated government claims that the Army will build on the Health Extension Program’s successes and help Ethiopia more

¹ The Amharic translation is *yesetoch lemat serawit*. Sometimes the Army is called, in English, the “Health Development Army,” and sometimes the “Health Transformation Army.”

quickly reduce its mortality rates and improve population health (e.g., Ramundo 2012; Desmond-Hellman 2014).

The idea of such an army reflects the unique history, ideology and style of government of Ethiopia's ruling coalition of parties, the Ethiopian Peoples Revolutionary Democratic Front (EPRDF), and of its former Prime Minister, Meles Zenawi. Much of the central committee of the EPRDF consists of leaders of the Tigrayan Peoples Liberation Front (TPLF), including the late PM, were Marxist-Leninist guerrilla fighters who in 1991 brought down the military regime that ruled Ethiopia since 1974 (the Derg).² Importantly, in the guerrilla struggle against the Derg in the 1980s, rural women were mobilized by the TPLF not only as auxiliaries, but also as leaders as fighters.³ Today, the EPRDF/TPLF leadership aims to run a strong, stable, authoritarian state. Described as “high-modernists,” the central party elite bases much of its legitimacy on its delivery of tangible “development” via government-devised programs and reforms, and considers its rural population a mass of “traditional” and dependency-prone people in need of discipline and mobilization, an ethos of self-reliance, and modern mentalities (Abbink 2012; Adem 2012; Easterly 2014). The struggle is no longer against the Derg, but instead said to be against rural people's own backwardness and lack of development (Little 2014).

There are potential conflicts between conceptualizations of the Army as empowering women, and the explicit emphasis that government health officials overseeing the Army and Health Extension Program have placed on the idea of disciplined citizens who maintain hygiene, seek out care according to government directives, and “follow the leader.” In this article, we

² For years, the Minister of Health who presided over the initial rollout of Ethiopia's Health Extension Program and Women's Development Army, Dr. Tedros Adhanom, has sat on the executive committee of the TPLF, the central core of political power in Ethiopia.

³ Azeb Mesfin, the wife of former PM Meles Zenawi, is the sole woman on the TPLF central committee. She and thousands of other women were fighters and platoon commanders. She has no doubt played a role in designing and promoting the WDA.

look at what are broadly recognized in the field of global health as two key features of any CHW program—selection and (non)payment of CHWs (e.g., Lehmann and Sanders 2007; Earth Institute 2013)—as entry points to understanding the complex ways in which the Women's Development Army is both “empowering” and subordinating women-citizens in new ways. We examine these issues (selection and payment) from the varied perspectives of district health officials, Health Extension Workers, and leaders and members within the Women's Development Army.

The research described here was carried out in the very early stages of the Women's Development Army rollout. As such, it provides insight into the top-down and bottom-up, participatory and technocratic, dynamics at play in the early days of the project. Our research shows that some of the most important aspects of the Army—from the perspectives of national and district state officials—involve disciplining women and getting them to carry out “missions that descend from above.” This discipline is supposed to lead to "empowerment," mostly within the family. Selection of the Army, too, is largely top-down in practice, with Health Extension Workers and district or local government officials often taking the lead. Many women selected as leaders are ambivalent about their new role given their existing responsibilities and lack of payment, while others say they are happy about the Army and its prospects for improving several aspects of their lives.

Methods

Our analysis draws primarily on interviews with national-level health officials and advisors in Addis Ababa (n=8), and an array of actors in six kebeles across three districts in the West Gojjam zone of Amhara state. These include district health officials (n=7, all men), Health

Extension Workers (n=11, all women), Army leaders (n=19, all women), and Army members (n=19, all women). We also draw on our review of numerous documents produced by the Ethiopian government and their international donors. With assistance from a young woman in nursing school in Bahir Dar who has worked with members of our research team for several years, we conducted a first wave of semi-structured interviews from October to December 2013. In June and July 2014, we conducted a second wave of follow-up interviews with six of the originally interviewed Health Extension Workers and eight of the originally interviewed Army leaders. We received approval to carry out this research from the ethical review boards of Oregon State University, Middlebury College and Addis Ababa University's Faculty of Medicine. We also received approval to carry out our research from Ethiopia's Federal Ministry of Health and the Amhara Regional Health Bureau in Bahir Dar.

Why Ethiopia Needs A Women's Development Army

Reducing Mortality Rates and Producing Model Women

High and/or stagnant maternal and child mortality rates and their corresponding Millennium Development Goal targets are routinely cited as the basis for major investments in Ethiopia's rural health care system (FMOH 2007; FMOH 2010; FMOH 2011; USAID 2010). The Health Extension Program is commonly identified by national and international health experts as the Ministry's "flagship" initiative and the "bedrock" of Ethiopia's attempts to expand primary health care.

The "philosophy" of the Health Extension Program hinges on creating more and more "model households," households that adopt a full package of healthy beliefs, desires, and behaviors, and that assume "responsibility" or "ownership" for their own health, particularly

with maintaining sanitation and hygiene, seeking antenatal checkups, and giving birth within health centers. Model households, the government further reasons, depend on model women in particular. As the name implies, model women are expected to get other women on board, and thus diffuse desirable beliefs and behaviors throughout the population (CNHDE 2011; FMOH 2007).

Five years into the Program, Ethiopia's Demographic and Health surveys showed stagnant maternal and neonatal mortality rates (Teklehaimanot and Teklehaimanot 2013). High-level officials have attributed these stagnant rates in part to their perception that the Health Extension Program did not sufficiently involve women and encourage them to seek antenatal care and to give birth in government health facilities. In addition, in the government's view many husbands were holding back their wives from becoming "model women," because doing so meant going against their conceptions of a homebound, quiet woman. Ethiopia's 2011 Ministry of Health Annual Performance Report (FMOH 2011) thus notes that there were many families "lagging behind" in terms of adopting a "healthy lifestyle."

Discipline and empower

The Women's Development Army reform is supposed to accelerate progress in creating model women by organizing, disciplining, and "empowering" select women as Army leaders, while convincing men to support their participation in the Army. As we examine below, Army leaders are supposed to be chosen based on specific criteria regarding their recognized potential to be a model for others. According to policy, leaders are given assignments, involving activities like mobilizing women for vaccination campaigns, registering births and pregnancies, and building latrines. Army leaders are also supposed to hold regular meetings with Army

“members” to discuss issues like women’s health and causes of infant death.

A recent article in *The Guardian* quotes Ethiopia’s current Minister of Health, Dr. Kesetebirhan Admassu, making clear the connection of the Women’s Development Army to a military, centering on the ideal of discipline: “Such a movement would not be successful without the discipline of the army... We said this is the way we really want to mobilise the community...they work with the discipline of an army” (Provost 2014). Army leaders are expected to be disciplined and to discipline other women citizens, and thereby diffuse a specific set of beliefs and behaviors that the central elite deems healthy and development-minded.

The Women’s Development Army thus aims to bring women out of the home and push them to socialize in a formal way fixated on health and hygiene. To “empower” women to participate more fully in Ethiopia’s development, district health officials say they need to convince men to support the greater participation and autonomy of women. Men, they say, typically influence every aspect of women’s lives, “taking every power for themselves,” and expect women to stay in the house and refrain from “meeting and discussing things together out of the house,” except perhaps at church. Thus the Army is supposed to solidify a pre-existing connection between disciplined women and domestic hygiene, while simultaneously “empowering” them to be more autonomous from husbands and more active in development-oriented work.

Army Leader Selection and Buy-in

Most CHW policies across the world emphasize community selection of CHWs, yet it is very hard to find ethnographic accounts of how CHW recruitment actually works (Lehmann and Sanders 2007:18). In rural areas, a common approach to community health worker recruitment

and selection is to set up village health committees that are responsible for selecting candidates (e.g., see Standing and Chowdhury 2008). Yet the actual manner of community health worker selection varies broadly (Perry, et al. 2014). As we show, the Women's Development Army offers an example of CHW selection in which some people who are selected resist the role.

Selection criteria: an ability to lead and a willingness to take orders

On paper, Army leaders are described as women who come from model households, who in turn are considered by Health Extension Workers to have “completed” or “graduated from” the Health Extension Program. The latter means adopting or otherwise conforming to the multiple Program “packages,” each of which consists of a bundle of beliefs, behaviors, and technologies (FMOH 2011). At the district level in our field sites, health officials and Health Extension Workers generally agreed upon criteria for selecting Army leaders. They should model “good behaviors” for others. Leaders, said district health officials, were chosen if they were “more active,” “better performing” of the Army's intended work, and “naturally gifted” to lead, coach, or coordinate other women. Multiple officials explained that leaders were the women who were able to “speak freely in front of others,” and who had “better thinking ability” or awareness and understanding of “what the Health Extension Workers teach them.” A Health Extension Worker clarified that the first criterion is reliability “when we call them for meetings.” She added that she and other HEWs prefer women “who accept what we teach them and who implement what we tell them.” “Even in school we categorize people in this regard,” one official asserted. “There are some who understand fast, some who understand later, and some who don't understand that much at all.”

While all officials we interviewed spoke in some way about role-modeling and leading

others, one official stressed a more explicitly hierarchical vision of leaders: women who are “able to disseminate the mission and information that descends from above” and “get members of the group to work together towards that mission.” These “leadership” and “model” qualities, according to district officials, correlate partially with higher economic status. One simply claimed that, “the leader is economically best” because she is best “able to produce or be fruitful in the work she performs.”

Army leadership criteria highlight the Ethiopian government’s aim to change local understandings of gender differences between men and women. Confident public speaking, leadership of others toward a lifestyle deemed healthy by the government, and attending meetings outside of the home are, in agrarian Ethiopia under the EPRDF, associated with men. Yet while the government says it is “empowering” women by turning them into Army leaders, one of the key criteria sought by health officials and HEWs—willingness to “accept what we teach them and implement what we tell them”—suggest that Army leaders are to remain subordinate to government health officials and HEWs.

Selection Processes: Autonomy and Coercion

Both district health officials and Health Extension Workers say that they give advice or instructions to women on how to select their leaders, and then let them make their own decisions. Many echoed a district health official who said, “They themselves select their leaders based on the criteria that we suggest, such that she will be a model for the group and will be able to lead.” A Health Extension Worker gave a more detailed account of the process:

First we convene about thirty women and discuss who is better and a model. We meet with these around their homes and identify the women

who are able to read and write and able to teach and model for others. So, they themselves select the leader... We only direct them to select, if possible, the women who can write, who are models, etc. Otherwise we do not interfere with the selection. If they select a woman who they think is good for them, we do not refuse, even if the mother is not able to write. We may accept the one they select and select somebody else who can write as her [co-leader].

Some Health Extension Workers and officials were adamant that “of course we [government officials and HEWs] do not select the leaders.” Yet others suggested that officials and HEWs play a more active role. For instance, one HEW said, “There are situations in which we [HEWs] lead the selection process and even decide with the kebele officials who is fit to be a leader. We then announce who are the leaders and who are the members.”

Army leaders and members themselves echoed what district officials and HEWs said about the selection of leaders. Some said that they had no say in who became a leader. Several leaders clarified that they had been chosen mainly because they were seen as particularly helpful in the agricultural sector, cooperating with government initiatives to improve agricultural productivity. One mentioned that she was chosen specifically because she had previously given birth in a health center, and another because she had previous experience working with an NGO in the health sector. Some leaders said they were glad to be chosen. One explained that she was happy to be a leader because she did not want people to suffer from various health issues, and because she wants women to give birth at health centers.

Yet several leaders suggested that they were hesitant to accept their nominations. These

women said that they did not want to take on the work burden, since they have abundant work to do already. Army leaders who said they were hesitant to accept their positions also said they were convinced by Health Extension Workers or government officials, who reassured them that they would only be working around their homes and not travelling far.

Some Extension Workers recognized that Army leaders had reservations about the role. One said, “There are leaders who say, ‘We haven’t taught the members because we do not have enough time’ ... This is because these mothers are very busy with farming work, in addition to domestic work and caring for children.” Another suggested that many women were becoming “bored” with being called for so many meetings and being given so many missions from officials. These HEWs’ perspectives on the matter perhaps reflect their “muted empathy” (cf. Nading 2013) towards the women they are supposed to serve and represent. But ultimately, we see that HEWs in addition to district officials generally aim to convince women to take on or “buy in” to the leader role.

The hesitancy expressed by some women about becoming leaders is an important reflection of the fact that the Women’s Development is meant to conscript *so many* women, and that it was never the agenda of Ethiopian women in the first place. In our interviews, women suggested what their own agendas might include: more health centers, located closer to their villages; increased selection/stock of medicines at government pharmacies, to preclude having to use private pharmacies where prices are too high; and warmer, better quality health care within health centers and hospitals—similar to the concerns heard in another part of Amhara (Banteyerga 2014). Instead, in our field sites women appear to be confronted with an agenda focusing on disciplining their own beliefs and behaviors.

Payment and Empowerment

In their article on the female community health volunteer program in Nepal, Glenton and colleagues claim that government officials see regular wages as both financially unfeasible and as a “potential threat” to the intrinsic satisfaction that volunteers gain (Glenton et al. 2010:1920). To rationalize a reliance on unpaid labor in community health, Ethiopian officials make distinct yet ultimately similar arguments, based on moral claims about empowerment and satisfaction, citizenship, self-sufficiency, and self-generated development (cf. Little 2014). Such arguments, wherever they occur, need to be contextualized. That is, we must ask questions about how transnational political economies motivate such arguments; how underpaid and unpaid community health workers both echo and contest these claims; and whether or not workers are involved in remuneration and other key policy decisions that impact them and the health care they provide.

Health Extension Workers and their Salaries

In the global health-development industry, there is a conventional conceptualization of sustainability—dubbed the “sustainability doctrine”—that prefers funding projects that will continue to exist after a few years of donor funding end (Swidler and Watkins 2009). In this approach, creating jobs and paying local labor with international donor funds is considered a bad idea, because these expenditures cannot be sustained by cash-strapped local organizations and governments when international funding pulls out. An unwillingness of some organizations to pay for local labor is also a result of the legacies of structural adjustment, which involved slashing government payrolls in order to balance government budgets (Pfeiffer and Chapman 2010; Dräger, et al. 2006; Ooms, et al. 2007).

However, in creating the Health Extension Program, the Ethiopian government used the rhetoric of sustainability in the service of creating paid jobs. Dr. Tedros Adhanom claimed that the success and sustainability of the Program hinged upon “engaging health extension workers as full-time salaried civil servants” and thereby “moving away from volunteerism” (FMOH 2010; WHO 2009). These statements echo the World Health Organization’s 2008 recommendation that “essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable” (WHO 2008). Thus high-level Ethiopian health officials and the WHO have mobilized a specific, progressive conceptualization of sustainability that counters the more conventional “doctrine” in the field of global health.

Health Extension Workers, therefore, have a salary of about 100 USD per month. Many HEWs said that this was not enough. For example a 29 year-old HEW explained:

The salary cannot cover the costs of living. Also, the work we do and the salary we get are very far apart. To fulfill our assigned work, we would need to work hard day and night. It is very difficult work. You can see people who sit in offices doing simple work. They get a salary of two thousand birr or more. But when you come to our salary, it is only 1427 birr, and we net only 1150 birr per month.... I want to leave this work if God allows. It would be much better to get an office or NGO job that pays a better salary and in which you can change your life, rather than doing this tiresome work with a salary that is less than 1500 birr.

Another Health Extension Worker from the same district added:

Our payment is better than nothing, but it is almost nothing when you compare it to your expenses. ... [Government officials] do not understand our effort and simply look to the quantitative evaluations. No one values that load we are carrying. This makes it difficult for us and de-motivates us.

Several HEWs asserted that their salaries are not enough to meet their basic expenses, which are rising due to inflation. The issue of pay was also consistently tied to issues of workload. Thus HEWs generally voiced desires not only for better pay, but also for Army leaders to become more active, because this would ease their heavy workloads. “Many of my tasks will be easier [with the Army],” one HEW said. “We [HEWs] will be able to more easily access pregnant mothers and advise them to attend ANC and to give birth at health centers.”

Health Extension Workers have such heavy workloads because Ethiopia’s Ministry of Health created only about 35,000 paid Health Extension Worker jobs to serve a population of 90 million. Central government officials, however, have avoided publicly stating that they may have created far too few HEW jobs. Instead, government leaders have focused on the need to sufficiently involve and discipline women. When we asked a mid-level Ministry official in 2012 about the decision to create an unpaid Army rather than more paid HEW jobs, he admitted that HEWs were “overburdened by several activities” and that the areas they covered and the population they served were “huge.” However, he said:

The Ministry is assuming that if these Development Armies are implemented effectively, the Health Extension Workers can train the Army members, and the Army members can [take over] the [promotive and preventive aspects of the

Health Extension Program]. So [there would be] no need of [Health Extension Workers] going to every household; they would just give instructions and then supervise this Development Army.

At the district level, many health officials echoed this line of thinking. One HEW supervisor explained:

In previous times, the HEW had to go to each house for her work, but now the HEW supports the development army leader... So, the person that the HEW now directly interacts with...has become closer.... The Army minimizes the workload of the HEW by limiting her connections.

The same official explained that this arrangement allows Health Extension Workers to “get data much faster”—specifically, data on which women are pregnant, experiencing illness, or building new and/or improved latrines. Another official, however, countered the norm, admitting that HEWs were overworked, even with the Army relieving them of some of their burdens.

There is a shortage of HEWs... The standard is one HEW for 2500 people, but in our context we are operating with a ratio of one HEW per 5000 people.... If the number of HEWs increases, the work will become easier for them because they will reduce their catchment area, and they will share the workload... Therefore, increasing the number of HEWs is important.

This district health official also said that the salary paid to Health Extension Workers was not attractive and was making it hard to fill empty positions. Thus some district officials admit a need for up to three or four times as many HEWs, and for higher salaries—a sign, perhaps, of empathy towards HEWs and of criticism of central government policy. Yet most do not openly admit this, perhaps because they do not feel comfortable openly questioning central government policy.

Many Health Extension Workers are unhappy about their workloads and pay. Some seek out other opportunities and livelihoods. Some ask to be re-assigned to kebeles that are closer to town and thus more desirable. But at present they have no opportunity for collective organization to change their work conditions. And even as they assert that their own pay is not enough, they must also attempt to convince Army leaders to accept the policy that they receive no payment at all.

Army leaders and their empowerment

Unlike HEWs, Army leaders are supposed to work without any payment, a policy that essentially overturns previous central government rhetoric about “moving away from volunteerism.” When asked to explain why Army leaders are unpaid, many district officials and Health Extension Workers turned to rhetoric about empowerment (vis-à-vis men and husbands) and intrinsic satisfaction. Through the Women’s Development Army, a district official claimed proudly, women “now have the freedom to communicate with their husbands,” and to converse with women and even other men outside of the home. “Being able to talk freely like men is a big change,” the district official said.

Such empowerment, district officials further claimed, improved women's lives. District officials said that by allowing Army leaders and members to increase their knowledge, expand their social networks, and “develop their leading ability” through new social interactions, the government reform was “making their lives better.” District officials argued that such empowerment provided emotional benefits to women—happiness—“even without payment”:

Starting from the leaders, they are all happy. I am not exaggerating when I say that women, in the past, used to be in the forest and knew nothing about leaving the village. Even leaving the home for health services was difficult due to the men's customs. Now, women are happy, even without payment, because being an Army leader or member means being able to talk freely and move outside the home like men.

Some district level officials also said that Army leaders should not be paid because they are not working for the government, but rather for themselves—that is, simply engaging in domestic and social activities that are expected of any decent woman-citizen. They claimed that Army leaders are being “empowered” to tend to their routine “house work” with more hygiene in mind; to take care of their *own* health; and to socialize with other women like they usually do, but now with a goal to spread and reinforce healthy household behaviors. One said, “They work for their own children, for their own families... So, the idea is that they should work without any payment by being committed to the development of their own community.” Another explained, “They are not working for somebody else but for themselves. Once they are made clear and aware of this, they work with the understanding that their work is totally for themselves.”

Another district health official claimed that women do not expect payment:

In previous times, it was the men who were attaching this [community health] work to incentives and needing incentives... But the women do not know such kind of incentives from the very beginning... The women do not expect money.⁴

Health Extension Workers had different views on leaders' desire for money, likely because being lower-ranked women they were more likely to hear complaints from leaders. One HEW told us that Army leaders had recently complained about being unpaid "for the same work that the men had been paid to do in the past." "They say that the government is cheating them and simply saying that men and women are equal. 'Otherwise, the government would have paid us the same,' they said." The leaders also argued, according to this HEW, that they should be paid because they lose time to do their house work while doing Army work and because they "wear out their shoes traveling house to house."

Yet many HEWs nonetheless said that it would be unwise to pay the Army leaders, "because if the payment stops at some point, the work will also stop." One HEW told us how she and her colleagues would respond to Army leaders' complaints:

We tell them that the payment has been stopped not because the government sees women as inferior to men. We also tell them that the

⁴ From the beginning of the Health Extension Program, large numbers of volunteer community health workers supported the Health Extension Workers, and many of these volunteers were men (CNHDE 2011; FMOH 2007). The number of volunteer community health workers was never tracked, but a very conservative estimate is that there were five volunteers for every Health Extension Worker. These volunteers were phased out and are being replaced by the Women's Development Army.

government used to get the money that was paid to the men from international organizations. We also remind them that some of the medical treatments they use also come through international aid. We try to convince them, saying “It is difficult for the government to pay you and pay for medical treatments for your children. So you should not complain.” We tell them that it is even a difficult and shameful thing for the government to ask for help from donors. We tell them therefore to avoid a sense of dependency on the government or on donors, and to help by doing the easy things that we are asking them to do.

Thus Health Extension Workers, along with the district level officials who supervise them, serve as mediators of both the so-called global “sustainability doctrine” and EPRDF ideology, introducing both global and national development rhetoric into the everyday lives of peasants (cf. Little 2014).

Many HEWs were sympathetic to leaders’ desire for pay. As one said, “everybody wants money.” Another Health Extension Worker said that she and other HEWs would sometimes share with Army leaders the per diems that they received for their work in vaccination campaigns. She also said that it would be good to pay the Army leaders, “because they will be motivated if they are paid.” But this same HEW also said that she had “advised” leaders that women “should own this work” and think of the work as “for themselves” and not as work that should require payment. “We tell them that the government is saying, ‘Development armies are self-sufficient and do not require support from others. Rather they can work hard and help themselves.’” Tellingly, this HEW also clarified that when Army leaders raise the issue of payment, “They do not raise that as a formal question or a right, of course.”

Rhetoric about working for oneself contradicts the fact that Army leaders are supposed to take over a good portion of the workload of Health Extension Workers. This rhetoric, furthermore, must be understood as a reflection of a specific central government ideology. The ruling party has made it clear that it aims to shape its citizenry into one that will not seek to support themselves through dependence on patronage and “rents,” but instead one that will be productive farmers and entrepreneurs, creating wealth and “development” for themselves and for the entire country (de Waal 2012; Little 2014; Segers et al. 2008; Brown and Teshome 2007; Zenawi 2012). Accordingly, Army leaders are expected to work without seeking “rent,” that is, without expecting any sort of payment. Thus, even as officials say they are empowering rural Ethiopian women to be more equal to men, officials at the district level value women specifically for the ways in which, unlike men, they are less likely to openly demand payment, which makes them, in this sense, better citizens than men.

What Army leaders say about payment and empowerment

Many Army leaders told us that they are happy and thankful for what the government is doing to or for them: empowering them, teaching them, making them modern, providing health care and other resources, and giving them more autonomy from husbands. Many Army leaders also echoed arguments that Army leaders work “for themselves” or for the good of their community and country, and not “for the government.” One twenty-five year-old woman said that, “there is no problem if you serve your country. You will get value from God for such work. And we should not be help-seekers from others; we should work hard and be self-sufficient.”

Many leaders further asserted that increased knowledge made up for a lack of monetary compensation. For example, a leader in her forties said, “Getting knowledge for myself and

passing knowledge to others could be enough. This is a big thing by itself.” She also said the work gave her satisfaction: “When the mothers I taught give birth and are healthy and happy, and when the children are vaccinated, I feel happy.” She said she wanted to continue being an Army leader because “the government has assigned this mission to us, and we will gain from it, and we will also make the community advantageous.” Another leader in her forties said she was happy to learn from the government that she should leave behind “many harmful traditional practices,” for instance treating children’s fevers at home through forms of cutting and bloodletting. “Now when our children have fevers we take them quickly to the health center.” She also claimed that she had learned how to resolve conflicts between husbands and wives through “compromising.”

Not all Army leaders were so convinced by government arguments about payment, knowledge, and empowerment. Some said that they were tired of working with the HEWs and “fulfilling the missions we are given.” “It is simply tiring for no benefit,” one leader said adamantly. Others seemed more apprehensive about expressing a desire for money. One laughed a bit uneasily as she said, “I mainly value the education I get and do not have that much intention to get money. But I don’t deny money if I can get it.” Another leader also laughed as she said, “It is good if the government thinks that we should get money. But it will not be good if we think like that and ask the government to give us money. The main thing for us is education and we should focus on that. But it will not be a problem if the government gives us money.” Several women were reluctant to voice complaints about pay on the record. A very active leader in her thirties, for instance, asked us to stop the voice recorder, and then proceeded to show us all of the lists of members and leaders, lists of pregnant women and mothers with infants, as well as other worksheets and forms she had filled out. “Look at all of this,” she said. “Isn’t this work? Shouldn’t I be paid for this too?”

On the issue of payment, there may be some limited potential for solidarity between HEWs and Army leaders. One twenty-five year-old Army leader said that, “Though there is no payment for us and they are paid, we are working together with [the Health Extension Workers].” Solidarity between Army leaders and members is also apparently possible. One of the Army members we interviewed, a woman in her twenties, suggested that, “Of course I think that [the leaders] should get payment. Those who are helping the HEWs well and working well should get money. They travel house to house to mobilize the community and help the HEWs by carrying vaccination equipment. They deserve to be paid.”

Yet despite critiques and opinions that Army leaders deserve to be paid or could at least benefit from being paid, at present these heterodox ideas are voiced neither loudly nor collectively. The same leader who showed us all her paperwork and suggested her work deserved payment revealed that she performed a role similar to that of the HEWs quoted above, by attempting to “advise” and “convince” other women who “are getting smart and asking to get money.”

They raise this question of getting money of course, but I advise and convince them. I tell them that we should not expect salary or per diem while we are working in our own areas and for the benefit of ourselves. I tell them my experience of getting no payment even for work that required me to travel to other places. So I try to convince them not to expect a salary.

In rural Ethiopia, the issue of payment further illustrates that community health workers are largely mediators of their government’s desire to discipline its citizenry, and not of popular

movements seeking better employment opportunities and fair labor practices. Policies of remunerating community health workers in Ethiopia—like community health policies in general—are decided at the top and handed down. Many Army leaders appear to accept government arguments about pay, knowledge, and empowerment (*vis-à-vis* husbands/men). Those that do not accept such arguments meet more rhetoric to convince them otherwise. Neither HEWs nor Army leaders participate in negotiating alternative policies, and this does not appear likely to change in the near future.

Discussion

Historically, community health workers have been closely connected to the idea of local community participation in health systems. In 1978, the Declaration of Alma Ata advocated the “full participation” of communities in health provision and emphasized that primary health care “requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care.” The Declaration’s emphasis on participation sent the message that health equity requires the ability of socially and politically marginalized people to *control* their health care system.

Following Alma Ata, community health worker programs were frequently conceptualized as being central to such community participation. However, many CHW programs in the 1980s were actually statist and top-down, rather than autonomous movements seeking health equity and social justice (Basilico et al. 2013). Such outcomes illustrate the durability and resistance to change of health care bureaucracies controlled by elites including doctors, government officials, and international donors (Nichter 1999). Lehmann and Sanders (2007) note that today’s CHW programs are much less likely to refer to goals of social justice and grassroots control than in

previous decades, and more likely to conceptualize CHWs as health technicians to be carefully recruited, trained, supervised, and retained by governments and NGOs.

Dr. Tedros Adhanom, Ethiopia's former Minister of Health, has explicitly connected the Ethiopian Health Extension Program to the Declaration of Alma Ata: "Our focus is primary health care... At Alma Ata, with the 'Health for All' declaration more than 30 years ago, the whole world said the focus should be on primary health care. But, in practice, that is the most neglected area today" (quoted in Donnelly 2011: 1908). As we have attempted to show here, the rollout of new national community health worker programs in Ethiopia took place through a process both more top-down and more complex than the one envisioned at Alma Ata.

Through the Health Extension Program and Army in Ethiopia, the central government has sought to discipline women and to get women to discipline, envy, and compete with each other. At present, these programs are ultimately devised and controlled by authorities. Ethiopia's central government also appears to recognize its duty (and interest) in offering new health infrastructures and quality services to rural citizens, with the help of its donors. Indeed, the Ethiopian government hands down not only notions of discipline and behavior change, but also tangible resources, including health centers and health posts, water wells, medicines, micro-credit, and women's affairs offices that help advocate on behalf of women when, for instance, their husbands or husbands' relatives attempt to dispossess them of land or other property.

Even as the central party pushes hard to discourage citizen "rent-seeking," at the district and kebele levels government officials encourage women to conceptualize what they receive from the state—education, empowerment, self-improvement—as patronage, deserving in return women's discipline, loyalty and unremunerated time. This new patron-clientism is not entirely unchallenged by rural women in Amhara. Many women in our study site appear to accept a

moral economy or social contract in which they receive empowerment, knowledge, and tangible resources from their government if they reciprocate with their own energy and time. Yet others carefully voice critique, suggesting that the government focuses too much on telling them what to do, and not enough on delivering more and better quality services.

Anthropologist Peter Little (2014), focusing on the agricultural sector of Ethiopia's development and poverty-reduction plans, presents a similar picture. In South Wello, another part of Amhara state, farmers say they are tired of being constantly “mobilized” and told how to behave and what to think by government authorities. Government officials clearly treat the agricultural and health sectors in Ethiopia clearly as complementary arenas in which to reform citizens and develop the country (cf. Adem 2012).

Our work highlights the important dimension of gender in these complementary arenas. We have shown that women and men are seen differently by state agents: men and to a lesser extent women are seen as important for improving agriculture, while women are seen as crucial to improving population health. Meanwhile, men are seen as a hindrance to women's empowerment in the health sector, and in development more generally. Men are also seen by some as overly self-interested, in contrast to women who are seen as uninterested in money and more willing to donate their time and labor to development efforts. Thus in both sectors, there is interest and effort on the part of government and donors to change men's attitudes and empower women to play bigger, more autonomous roles in households and community level activities. Women and men, furthermore, resist the aims of government workers to shape their thinking, relationships, and actions. Our work also reveals important instances in which district level officials (who tend to be men) question central policies that create heavy workloads and low (or nonexistent pay) for women.

There are competing, or perhaps complementary, explanations for the variation that we observe in how the Army is rationalized by higher and district level officials, in how selection of leaders is carried out, and in how women react to being selected as unpaid leaders. On the one hand, variation exists in the extent to which district officials, HEWs, and Army leaders/members internalize and agree with the rhetoric, goals, and rationales of the state (regarding, e.g., “rent-seeking” and “dependency”) and of the global health industry (i.e., the sustainability doctrine). On the other hand, it could be that many people who say they agree and accept what they are told by agents of the state, actually disagree yet are reluctant to voice their alternative viewpoints and critiques, for fear of negative repercussions, including confiscated land, fines, labels of rent-seeking, dependency, or opposition, and designations of un-deservingness of welfare resources made available through the state (Little 2014; Harrison 2002).

Attention to these complexities—the tensions between top-down and bottom-up approaches to development, the relationships of citizens with the state and its global donors—are central to understanding CHW programs, and are relentlessly context specific. Anthropology has much to offer here. Rather than a somewhat naïve conceptualization of “participation” and “empowerment” as existing outside of political and historical context, work on CHWs can illuminate how these workers fit into existing political structures, and how these structures may undercut ideals of empowerment and participation. Future research in Ethiopia will need to examine the ways in which rural women in different parts of the country use the Army to define their own agendas and hold government and development partners accountable for their actions. It will be particularly important to carefully understand when respondents are being careful to toe the party line. In-depth ethnographic work, involving participant observation and interviews based on trust and expectations of confidentiality and impartiality, can paint a nuanced picture of

how state elites, low-level workers, and peasants cooperate and come into conflict in their varied attempts to improve community health. As part of the anthropological project, it would also be productive to explore even faint reflections of empathy and solidarity between officials and health workers, so that these important and sometimes scarce resources might be nurtured and amplified. Doing so will hopefully point the way to better policy making and implementation, by pointing to locally-meaningful knowledge and possibilities for innovation (Maes, et al. 2014).

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